STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR RIDGE	2700 WATERS EDGE PKWY JEFFERSONVILLE, IN 47130

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R0000	This visit was for a State Residential Licensure Survey. Survey dates: July 2, 3, 5, 2012 Facility number: 004001 Provider number: 004001 AIM number: N/A Survey team: Donna Groan, RN-TC Dorothy Watts, RN Census Bed Type: Residential: 33 Total 33 Census Payor Type: Other: 33 Total 33 Sample: 07 Supplemental sample: 04 These state residential findings are cited in accordance with 410 IAC 16.2. Quality review completed 7/10/12 by Jennie Bartelt, RN.	R0000	Submission of this Plan of Correction does not constitute an Admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and Submitted because of State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0273	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and record review, the facility failed to ensure a hand hygiene policy was followed for 1 of 1 observation during meal preparation. This deficient practice had the potential to affect 33 residents who reside in the facility. Findings include: On 7/2/12 between 11:30 a.m. and 12:00 p.m., the following was observed: Cook #1 was observed to go to the hand sink to wash her hands. Time of 10 seconds elapsed during the hand washing. After obtaining a temperature for the macaroni and cheese and returning it to the oven, she wiped the counter top with sanitizer and proceeded to the garbage can and then went to wash her hands. Time of 5 seconds elapsed during the handwashing procedure. On 7/3/12 at 2:20 p.m., the Dietary Manager provided the Hand Washing Policy for the Dietary Department. The policy included, but was not limited to : "Procedure: 1. Hands are washed c.	R0273	1. No residents were harmed. Cook #1 was immediately re-educated on the facility's Handwashing policy. 2. All residents have the potential to be affected. 3. All dietary staff have been in-serviced on the facility's Handwashing policy, (see attachment A). As a measure to ensure ongoing compliance, the Dietary Manager or designee will complete an audit daily on regularly scheduled days for 1 month, then twice weekly for 1 month, then weekly for 1 month, then monthly thereafter to ensure hands are washed per facility policy, (attachment B). 4. As a measure of quality assurance the Dietary manager will complete the above described monitoring ongoing on a monthly basis. Should a deficient practice be observed, immediate corrective action will be taken. The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongoing. The plan of correction will be revised accordingly, if warranted.	07/18/2012

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	After taking out garbage, putting away stock, cleaning... 2. Handwashing Procedure: d. Hands must be washed for a minimum of 20 seconds." On 7/2/12 at 3:15 p.m., the Residential Care Administrator provided the facility Handwashing/Hand Hygiene Policy and Procedure revised 3/07 which included, but was not limited to: "Handwashing Procedure: ...5. Lather all areas of hands and wrists, rubbing vigorously. Wash between your fingers, the backs of your hands, your palms, and around your fingernails. Continue this scrubbing action for at least ten seconds. Clean your nails by rubbing them in the palm of your other hand. Please note, food service employees shall perform this scrubbing action for at least 20 seconds."			

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R0298	410 IAC 16.2-5-6(c)(2) Pharmaceutical Services - Deficiency (2) A consultant pharmacist shall be employed, or under contract, and shall: (A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on record review and interview, the facility failed to ensure a resident's drug regimen was reviewed by the pharmacist every 60 days for 1 of 7 residents reviewed for drug regimen review by pharmacy in a sample of 7. (Resident #4) Findings include: The clinical record for Resident #4 was reviewed on 7/3/12 at 9:10 a.m. The record indicated the resident was admitted to the facility on 5/21/11. Documentation was lacking of a pharmacist drug regimen review for the months of October and December 2011, February and April, 2012. In interview with the Residential Care	R0298	1. Resident #4 was not harmed. The Pharmacy Consultant had reviewed resident #4's medication regimen every 60 days. 2. All residents have the potential to be affected. All residents have had their medication regimen reviewed by the consultant pharmacist. 3. The DON has been re-educated on the Consultant Pharmacist visit reports and recommendations, (attachment C). The Pharmacy Consultant report includes any recommendations being made and list of residents that have had their medication regimens reviewed with no recommendations made. The DON or designee will complete an audit with each consultant visit report to ensure the Consultant Pharmacist has reviewed all residents' medication regimens at	07/18/2012

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	Administrator on 7/3/12 at 9:32 a.m., he indicated the pharmacist was just in the other day, but could not locate the visit in the clinical record. At 10:20 a.m., he indicated he could not find the documentation. On 7/5/12 at 10:30 a.m., the Residential Care Administrator provided the Medication Review/Recommendations Policy dated revised 11/08 which included, but was not limited to: "POLICY: The Consultant Pharmacist shall also be responsible for the periodic review of the drug regimen of each resident for whom the facility is responsible for medication administration. Review should be conducted at least every 60 days."		least every 60 days, (attachment D). 4. As a measure of quality assurance the DON will complete the above described monitoring ongoing on a monthly basis. Should a deficient practice be observed, immediate corrective action will be taken. The Administrator will monitor and sign off on the monitoring tools ongoing. The plan of correction will be revised accordingly, if warranted.	

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R0302	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation, interview, and record review the facility failed to label over-the-counter medication with the residents name and/or the prescribing physician's name on 1 of 2 medication carts observed. (Resident # 9, 10, 11, 12) Findings include: 1. On 7/3/2012 at 12;33 P.M., while reviewing the medications on the medication cart it was observed Resident # 9 had four OTC (over-the-counter) medications that did not have labels with the prescribing physician's name on the bottle. One OTC bottle had neither the resident's name nor the prescribing physician's name on the label. The medications were as follows: OS-Cal calcium + D 3, Vitamin C 500 mg, Aspirin 81 mg, Centrum Chewable Vitamins, and Prilosec OTC 20.6 mg. 2. Resident #10 had a bottle of Vitamin C 500 mg with no label identifying the resident or the prescribing physician's	R0302	1. Complete labels were placed on the medication containers for resident #9, 10, 11, and 12. 2. All residents with OTC medications have the potential to be affected. All medication carts were checked to ensure all medications have an appropriate label in place. 3. All nursing staff in-serviced on the facility's policy on Over-the –Counter medications, (attachment E). The DON or designee will complete an audit weekly for 1 month, then every other week for one month, then monthly to ensure all medications have an appropriate label, (attachment F). 4. As a measure of quality assurance the DON will complete the above described monitoring ongoing on a monthly basis. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if warranted. The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongoing.	07/18/2012

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	name. 3. Resident #11 had two OTC medication bottles with no label identifying the prescribing physicians's name. The medications were as follows: Melatonin 3 mg, Aspirin 81 mg. 4. Resident #12 had two OTC medication bottles with no labels identifying the prescribing physician's name. The medications were as follows: Multivitamins/Multiminerals Supplement 400 IU vitamin fiber Capsules, Multivitamins. The clinical records were reviewed on 7/3/2012 between 1:00 P.M. and 1:25 P.M. for Residents #9, #10, #11, and #12, indicated they had current medication orders from their physicians for the above named medications. In interview with LPN #1, at this time, she indicated the medications belonged to the residents. The Facility Policy and Procedure for Over-The-Counter Medications, provided by the Residential Care Administrator was reviewed on 7/3/2012 at 1:06 P.M. The procedure included, but was not limited to: "The hand written legible label placed by licensed staff on the manufacture's container/bottle shall include the following: Resident Name and			

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	Physicians Name." On 7/3/2012 at 12:45 P.M., during an interview with LPN # 1 she indicated all the OTC medications need to have a label with the resident's name and the physician's name on the bottle.			

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R0354	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance (g) A transfer form shall include the following: (1) Identification data. (2) Name of the transferring institution. (3) Name of the receiving institution and date of transfer. (4) Resident ' s personal property when transferred to an acute care facility. (5) Nurses ' notes relating to the resident ' s: (A) functional abilities and physical limitations; (B) nursing care; (C) medications; (D) treatment; and (E) current diet and condition on transfer. (6) Diagnosis. (7) Date of chest x-ray and skin test for tuberculosis. Based on record review and interview, the facility failed to send a transfer form which included nursing notes related to the resident, and functional abilities and limitations, date of chest x-ray and skin test for tuberculosis,with 3 residents when they were transferred to another facility. This deficient practice affected 3 of 3 residents reviewed with transfers in a sample of 7 residents. (Resident #1, Resident #7, and Resident #6) Findings include: 1. The clinical record for Resident #7 was reviewed on 7/3/12 at 9:45 a.m. The resident was sent out to the hospital on 4/4/12 for a fall/head injury. The Transfer	R0354	1. No resident was harmed related to the transfer sheet documentation.2. All residents being transferred to another facility/home have the potential to be affected.3. All nursing staff in-serviced on completing the transfer sheet completely, (attachment G). The DON or designee will complete an audit tool weekly for 1 month, then every other week for 1 month, then monthly to ensure all transfer forms are completed thoroughly, (attachment H).4. As a measure of quality assurance the DON will complete the above described monitoring ongoing on a monthly basis. Should a deficient practice be observed, immediate corrective action will be taken. The plan of correction will be revised accordingly, if	07/18/2012

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	Form was blank for the following information, which included, but was not limited to: Personal Hygiene, Dressing, Locomotion, Behavior, Mental Status, and Communication. The transfer sheet also lacked the date of the chest xray and last Mantoux (tuberculosis test) with results. 2. The clinical record for Resident #1 was reviewed on 7/2/12 at 2:15 p.m. The resident was sent out to the hospital on 7/2/12 for treatment and evaluation for fall/head injury. The Transfer Form was blank for the following information: Personal Hygiene, Dressing, Locomotion, Behavior, Mental Status, and Communication. The Transfer Form also lacked the date of the chest xray and last Mantoux (tuberculosis test) with results. On 7/5/12 at 9:45 a.m., in interview with the Resident Care Administrator, he indicated he would expect the nurses to fill in the Transfer Form completely. 3. On 7/3/12 at 10:05 a.m., Resident #6's chart was reviewed. The Patient Transfer/Discharge Summary dated 5/19/12 was blank for the following information: Personal Hygiene, Dressing, Locomotion, Behavior, Mental Status, and Communication. The form did not have a date for the chest x-ray, dates and		warranted. The Administrator will monitor and sign off on the monitoring tools on a monthly basis ongoing.	

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	results for the Mantoux test and the functional abilities and limitations for the resident.			